

IN THE SUPERIOR COURT OF WASHINGTON
FOR THE COUNTY OF KING

In the Guardianship of: _____) Case No.:
_____)
_____) MEDICAL/PSYCHOLOGICAL REPORT
_____)
_____) (MDR)

**This form is required by Washington state law for all Guardianships. Your assistance in completing this form on or before _____ is appreciated.
(Please type or print clearly.)**

I have been chosen by the Guardian ad Litem in the above matter to examine and interview _____, and I submit the following report:

My name, title, address, telephone number are as follows:

_____.

A. My education and experiences that are pertinent to the type of disorder or incapacity involved in this case: *(a resume/curriculum vitae may be attached.)*.

B. Date of most recent examination of the Alleged Incapacitated Person (most recent exam must be within 30 days of date of this request): _____

C. A summary of the relevant medical functional, neurological, psychological, or psychiatric history of the Alleged Incapacitated Person as known to me:

_____.

D. My findings as to the Alleged Incapacitated Person is as it relates to capacity to manage personal or financial matters is: _____.

E. The following medication(s) are currently prescribed to the Alleged Incapacitated Person for the following condition(s).

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Medication: _____ Condition: _____

F. The effect of these current medications on the Alleged Incapacitated Person's ability to understand or participate in the Guardianship proceedings is:

_____.

G. My opinions as to the specific assistance the Alleged Incapacitated Person needs (*including items such as household chores, managing finances*):

_____.

H. I have also met or spoken with the following individuals regarding the Alleged Incapacitated Person: _____.

I certify (or declare) under penalty of perjury under the laws of the State of Washington that to the best of my knowledge the statements above are true and correct.

SIGNED AT _____, WASHINGTON THIS _____ DAY OF _____, 200____

Signature of Physician/Psychologist/ARNP

Printed Name of Physician/Psychologist/ARNP

Address

Telephone/Fax Number

City, State, Zip Code

Email Address